STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	01/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

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F0000	This visit was for the Recertification and State Licensure Survey. This visit also included the Investigation of Complaint IN00101871. Complaint IN00101871 - Substantiated. Federal/State deficiencies related to the allegations are cited at F244, F314 and F441. Survey Dates: January 9, 10, 11, 12 and 13, 2012 Facility number: 000476 Provider number: 155446 AIM number: 100290870 Survey team: Julie Wagoner, RN, TC Tim Long, RN Christine Fodrea, RN Census bed type: SNF/NF: 134 Total: 134 Census payor type: Medicare: 15 Medicaid: 81 Other: 38 Total: 134	F0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Sample: 24 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 1/23/12 by Suzanne Williams, RN			

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F0244 SS=E	When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.			
	Based on interview and record review, the facility failed to resolve grievances made by residents in group meetings for call light response, food temperature and ice water three times daily. These concerns affected nine of ten residents present at the group meeting (Resident # N, O, P, Q, R, S, T, U, W) and 4 of 5 additional residents individually interviewed (Residents #X, Y, Z, and A). These residents resided on 3 of the 4 nursing units in the facility. Findings include: On 1/10/12 at 10:00 A.M., a meeting was conducted with ten alert and oriented residents.(Residents #M, N, O, P, Q, R, S, T, U, and W) Six of ten residents indicated call light response was not fast enough. Nine of ten residents indicated the temperature of hot food was not always appropriate. Seven of ten residents indicated they were not offered fresh ice water each shift routinely. Review of the resident council minutes from June 2011 through December 2011 indicated: Residents complained about	F0244	1. Outstanding grievances have been reviewed for follow-up 2. Resident council met on January 25 th , 2012. Old business was reviewed including call lights, food temperatures, and ice water. The resident stated notable improvementl. 3. Facility staff will be in serviced on answering call lights timely. Nursing and dietary staff will be in serviced concerning passing ice water three times daily and ensuring food is passed timely to ensure proper food temperatures. The ED/designee will audit 5 instances weekly of ice water passing and call lights times for appropriate completion. The Dietary manager/designee will monitor 5 instances weekly of food temperatures to ensure compliance. Grievance follow-up from	02/12/2012

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	slow call light response July 2011, August 2011, September 2011, October 2011, November 2011 and December 2011; residents complained about not getting fresh ice water routinely September 2011; Residents complained about food not being served hot food, June 2011. A response form, to the October 2011 concern regarding nursing call light response, indicated more staff had been added but it was an "ongoing" problem the facility was working on resolving. The nursing response to continued Resident Council concerns on November and December 2011 regarding lengthy call light response times indicated they "were continuing to monitor the situation" and were "measuring progress" by adding additional managers on evenings and weekends to "measure progress." There was no specific information regarding the results of the measurements, and the added management staff did not resolve the issue with call light response times. During an individual interview with resident #X on 1/13/12 at 11:00 A.M. it was indicated the food was not always hot when she ate in her bedroom. During an individual interview with resident #Y on 1/12/12 at 1:25 P.M., it was indicated the food was often not hot		resident council will be reviewed on the following month. If a solution is not met the ED/designee will meet with the council to discuss further intervention. 1.Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter.	

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	enough. Resident #Y also indicated call light response sometimes included staff asking what he wanted, then leaving and not coming back. Resident #Y also indicated he usually gets fresh ice water once daily. During an individual interview with resident #Z on 1/12/12 at 2:15 P.M., it was indicated the food that should have been hot was sometimes cold. Resident #Z also indicated call light response sometimes included staff ask turning off the call lights and say they will come back and then don't return. Resident #Z also indicated she usually gets fresh ice water once daily. During an individual interview with resident #A on 1/10/12 at 11:30 A.M., it was indicated the food was mostly served cold. Resident #A also indicated she doesn't get ice water served to her. This Federal citation relates to Complaint IN00101871. 3.1-3(l)			

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F0253 SS=B	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to maintain feeding pumps and portable blood pressure cuff in clean condition during storage. This had the potential to affect 27 residents on the Rehab unit. Findings include: During environmental tour on 1-11-2012 at 9:32 a.m., in the Central Supply area on the Rehab unit, the blood pressure cuff mounted on a rolling pole was observed to be coated with a gray feathery substance. Next to the blood pressure cuff was a feeding pump that was observed to have multiple brown spots resembling splashes on the front and back of the pump as well as the pole on which the pump was mounted. In an interview on 1-13-2012 at 9:10 a.m., the Director of Nursing indicated 27 residents were on the Rehab unit and all had routine blood pressures taken. On 1-11-2012 at 9:32 a.m., the Housekeeping supervisor indicated in an interview, the area was the Central Supply area and the equipment contained in that area was supposed to be clean and ready	F0253	1. The identified feeding pumps were cleaned and portable blood pressure cuff was discarded. 2. All feeding pumps will be reviewed for cleanliness with follow up necessary. The facility does not have any other rolling blood pressure cuffs. 3. Nursing and housekeeping will be in-serviced that feeding pumps placed into storage are to be cleaned thoroughly so to be ready for use. The Environmental Director/designee will audit stored feeding pumps 2 times a week for cleanliness 4. Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter. Addendum It is currently part of the infection control program to use an approved disinfectant for cleaning equipment between resident uses in accordance with manufacturers recommendations	02/12/2012

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	for use. On 1-12-12 at 3:59 p.m., the Administrator indicated in an interview, although there was no specific policy regarding clean equipment, it was understood equipment would be kept clean and usable. 3.1-19(f)			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to ensure a care plan was developed for bowel and bladder incontinence needs for 1 of 24 residents reviewed for care plans in a sample of 24. (Resident #150) Finding include: The closed clinical record, reviewed on 01/13/12 at 10:00 A.M., for Resident #150, indicated she was admitted to the facility on 10/23/11 with diagnoses, including but not limited to, recent fracture of the pelvis, intractable pain issues, and dementia.	F0279	1. Resident #150 was discharged from the facility prior to survey. 2. The facility will review all current residents to ensure a care plan has been developed to address bowel and bladder incontinence. 3. The staff responsible for completing the MDS will be in serviced to develop care plans to address resident's bowel and bladder incontinence. DNS/designee will monitor compliance through	02/12/2012

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	A "Bowel and Bladder Assessment and Management" form, completed on 10/23/11, the resident's admission date, indicated the resident was incontinent of both her bowels and bladder but the incontinence occurred less than 7 times. The resident's "score" indicated she was a candidate for a possible re-training or individualized training program. The initial MDS (Minimum Data Set) assessment for Resident #150, completed on 10/29/11, indicated the resident was frequently incontinent of her bowels and bladder and required extensive staff assistance for toileting needs. The CAA (Care Area Assessment) for the incontinence section of the 10/29/11 MDS assessment indicated the resident was going to be on a "Scheduled toileting" program. Review of the health care plans for Resident #150, initiated on admission, and current through the resident's discharge from the facility on 12/02/11, indicated there was no plan regarding toileting and/or incontinence needs. Interview with the MDS coordinator, LPN #4, on 01/13/12 at 11:00 A.M., confirmed there was no further assessment of the resident's incontinence, other than the one completed the day of the resident's		auditing 5 resident care plans weekly. 4. Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter	

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	admission, and there were no care plan initiated which addressed specific toileting needs or incontinence needs. 3.1-35(a)			

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F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	1. Based on record review and interviews, the facility failed to ensure physician orders regarding blood sugar testing, insulin administration, and follow up testing were followed for 4 of 24 residents reviewed for physician's orders in a sample of 24. (Residents #D, E, 62, and 79) 2. Based on observation, record review and interview, the facility failed to follow physician's orders for reduction in psychoactive medication for 1 of 4 residents reviewed for psychotropic medication reduction in a sample of 24. (Resident #106) Findings include: 1. a. The clinical record for Resident #62 was reviewed on 01/12/12 at 10:00 A.M. Resident #62 was admitted to the facility on 08/01/11 with diagnoses including, but not limited to, diabetes. The current physician's orders included orders, dated 10/18/11 to test the resident's blood sugar level before meal times and at bedtime. The orders also included instructions to call the physician for blood sugar levels below 50 or above 300. The orders also indicated if the resident received "HS"	F0282	1. Residents #D, E, 62, and 79 MD's were notified of elevated blood sugar levels and amount of insulin administered. Resident #106 MD was notified of the lack of transcription for reduction in psychotropic medication. 2. Residents on psychotropic medication will be reviewed to ensure MD recommended reductions have been implemented. Residents receiving blood sugar checks will be reviewed to ensure MD notification and correct insulin dosages have been given with MD notification as appropriate. 3. Licensed staff will be in serviced to follow MD orders regarding calling the MD of blood sugar levels outside ordered parameters and administering sliding scale insulin correctly. Licensed staff will be in serviced to complete MD orders for psychotropic	02/12/2012

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	bedtime coverage then the blood sugar level was to be rechecked within 30 minutes range and again at 12 AM as needed. Novolin R on a sliding scale was ordered as follows: "151 - 200 = 2 units, 201 - 250 = 3 units, 251 - 300 = 4 units , greater than 300 = 6 units." Finally, the physician's orders included instructions to document in the nursing notes the initial blood sugar, the call to the physician, any new orders from the physician, and any signs and/or symptoms of hypo/hyperglycemia. Review of the November 2011 Medication Administration Record indicated on November 2, 4, and 5, 2011 the resident's blood sugar levels at 4 PM, were 304, 318, and 308 respectively. On 11/02/11, 4 units of insulin was documented as having been administered, and on 11/4/11 4 units was insulin was documented as having been administered. Review of nurse's notes, on 11/02/11, 11/04/11, and 11/05/11 indicated there was no documentation of the elevated blood sugar levels, any physician notification, or any signs and/or symptoms of hyperglycemia. Interview with the Director of Nursing, on 01/12/12 at 3:10 P.M. indicated she had spoken with the nurse who was working on 11/02/11, 11/04/11 and 11/05/11 and		medication reduction timely. UM/designee will monitor compliance with blood sugar notification and sliding scale insulin administration through the medical record audit 5x weekly. SS/designee will monitor compliance with psychotropic reduction recommendations monthly. 1.Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter.	

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	she had not notified the physician of the elevated blood glucose levels and had administered the incorrect insulin coverage amount of two of the three days. 1.b. Resident #E's record was reviewed 1-10-2012 at 11:30 a.m. Resident #E's diagnoses included, but were not limited to, depression, diabetes, and dementia. Current physician's orders dated January 2012, indicated the following sliding scale insulin coverage had been ordered on 3-7-2011: 181-240 give 4 units 241-300 give 6 units 301-350 give 8 units 351-400 give 10 units greater than 400 give 12 units and call the physician. A review of the Medication Administration Record (MAR) dated 12-2011 indicated on 12-18-2011 at 11 a.m. Resident #E's blood sugar was 400 and was given 12 units of Humulin R coverage. Resident #E should have been given 10 units of insulin coverage. The MAR further indicated Resident #E's blood sugar on 12-20-2011 at 11 a.m. was 300 and was given 8 units of coverage. Resident #E should have been given 6 units of insulin coverage.			

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	A review of the MAR dated 11-2011, indicated 8 p.m. blood sugars had been obtained, but no coverage had been given for the following blood sugars: 11-1; 203 should have been given 4 units, 11-3; 218 should have been given 4 units 11-4; 292 should have been given 6 units 11-5; 292 should have been given 6 units 11-6; 205 should have been given 4 units 11-7; 193 should have been given 4 units 11-8; 203 should have been given 4 units 11-9; 230 should have been given 4 units 11-10; 197 should have been given 4 units 11-11; 293 should have been given 6 units 11-12; 368 should have been given 10 units 11-13; 315 should have been given 8 units 11-16; 201 should have been given 4 units 11-18; 211 should have been given 4 units 11-19; 293 should have been given 6 units 11-20; 380 should have been given 10 units 11-21; 256 should have been given 6 units 11-22; 215 should have been given 4 units 11-23; 222 should have been given 4			

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	units 11-24; 213 should have been given 4 units 11-26; 270 should have been given 6 units 11-27; 195 should have been given 4 units 11-28; 219 should have been given 4 units 11-29; 191 should have been given 4 units 11-30; 204 should have been given 4 units A review of the MAR dated 12-2011, indicated 8 p.m. blood sugars had been obtained, there was a hand written note on the MAR that indicated to give no 8 p.m. coverage. A review of the current physician's orders did not include to give no coverage for the 8 p.m. blood sugars. No coverage had been given for the following blood sugars: 12-1; 294 should have been given 6 units, 12-2; 281 should have been given 6 units 12-3; 202 should have been given 4 units 12-4; 198 should have been given 4 units 12-6; 183 should have been given 4 units 12-7; 236 should have been given 4 units 12-10; 297 should have been given 6 units 12-11; 256 should have been given 6 units 12-13; 185 should have been given 4			

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	units 12-14; 219 should have been given 4 units 12-16; 219 should have been given 4 units 12-17; 207 should have been given 4 units 12-18; 220 should have been given 4 units 12-19; 211 should have been given 4 units 12-20; 238 should have been given 4 units 12-21; 225 should have been given 4 units 12-22; 205 should have been given 4 units 12-23; 245 should have been given 6 units 12-24; 279 should have been given 6 units 12-25; 229 should have been given 4 units 12-26; 256 should have been given 6 units 12-27; 297 should have been given 6 units 12-28; 223 should have been given 4 units 12-29; 209 should have been given 4 units In an interview on 1-12-2012 at 1:10 p.m. LPN #2 indicated coverage should have			

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	been given at 8 p.m. as ordered. 1. c. Resident #D's record was reviewed 1-11-12 at 1:00 p.m. Resident #D's diagnoses included, but were not limited to, heart failure, diabetes, and kidney disease. A current physician's order dated 12-16-2011, indicated to call the physician for blood sugars over 300 and to repeat the blood sugar in 30 minutes. A review of the MAR dated 11/11 indicated the following blood sugars were obtained: 11-2 at 4 p.m. 331 11-2 at 8 p.m. 389 11-3 at 4 p.m. 358 11-3 at 8 p.m. 354 11-4 at 4 p.m. 304 11-5 at 11 a.m. 320 11-6 at 8 p.m. 353 11-7 at 8 p.m. 323 11-9 at 8 p.m. 329 A review of the MAR and nurse's notes for the above referenced dates did not indicate blood sugars had been obtained after 30 minutes. 1. d. Resident #79's record was reviewed 1-12-12 at 11:45 a.m. Resident #79's diagnoses included, but were not limited			

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	to, diabetes, depression, and stroke. A current physician's order dated 12-11, indicated to repeat blood sugars within 30 minutes if the blood sugar was over 300. A review of the MAR dated 12-2011 indicated on 12-21 at 4 p.m. Resident #79's blood sugar was 306. There was no indication on the MAR the blood sugar had been rechecked after 30 minutes. A review if the nurse's notes for 12-21-2011 at 4 p.m. did not indicate the blood sugar had been rechecked after 30 minutes. In an interview on 1-12-12 at 2:15 p.m., LPN # 3 indicated the blood sugars should have been rechecked within 30 minutes as ordered. 2. Resident #106's record was reviewed 1-9-2012 at 11:59 a.m. Resident #106's diagnoses included, but were not limited to, dementia, depression, and high blood pressure. On 1-9-2012 at 11:45 a.m. Resident #106 was observed sitting in her wheelchair, leaning over, sleeping. Resident #106 was awakened to eat several times, but went back to sleep until a CNA came over and			

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	finished feeding her with running conversation to keep her awake enough to eat. On 1-9-2012 at 2:05 p.m. Resident #106 was observed in her room sleeping. In an interview on 1-9-2012 at 2:20 p.m. LPN #3 indicated Resident #106 was always sleeping these days. On 1-10-2012 at 8:30 a.m., Resident #106 was observed up in her wheelchair in the lounge area head bent to chest sleeping. On 1-10-2012 at 9:00 a.m. Resident #106 was observed in the dining area during an activity with her head on her chest sleeping. A current physician's order dated 1-12, and originally ordered 1-31-2011, indicated to give Lexapro (an antidepressant) 20 milligrams daily. A pharmacy recommendation signed by the attending physician 12-1-2011, indicated Lexapro was to be decreased to 10 milligrams every day. A note on the bottom of the recommendation indicated the recommendation and medication decrease had been faxed to the psychiatrist. There was no further note the psychiatrist had gotten the fax, had			

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	responded to the note or why the medication had not been reduced. In an interview on 1-12-2012 at 10:00 a.m., the Administrator indicated there was no specific policy for following physician's orders, it was understood they would be followed. 3.1-35(g)(2)			

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on observation, record review, and interview, the facility failed to thoroughly assess reddened skin and scabbed areas for 1 of 6 residents reviewed for pressure ulcers in a sample of 24. (Resident H) Findings include: 1. During the initial tour of the facility, conducted on 01/09/12 between 10:30 A.M. - 11:00 A.M., RN #7, the unit manager, indicated Resident H was had a pressure area where a cast had rubbed prior to being removed. She indicated the resident could not bear weight due to a fractured ankle. During observation of the resident's pressure ulcer, on 01/10/12 at 10:45 A.M., a crescent shaped pressure ulcer was noted on the outer ankle bone of the left ankle. However, there was markedly reddened skin noted around the resident's heel and extending in a linear fashion from the back of the resident's heel to the front of the resident's shin. The resident's shin had a nickel sized scabbed area and several smaller scabs and/or moist open	F0309	1. Resident #H was discharged home. 2. All residents have been reviewed to ensure skin conditions have measurements and documentation in place. 3. Licensed staff have been in serviced regarding completing resident skin assessments including obtaining measurements and documentation of findings. UM/designee will monitor compliance through 5 random skin assessment validations weekly to ensure skin measurements and documentation is accurate. 1.Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter.	02/12/2012

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	areas noted within the reddened area on the shin. The resident's entire left lower extremity was noted to have dry, scaly skin which the resident indicated he had before his ankle fracture. He indicated he did not have the reddened area prior to his ankle fracture. Review of the resident's clinical record, on 01/09/12 at 2:47 P.M. indicated the resident's pressure ulcer had been assessed and "surround skin pink/purple" was documented, but there was no thorough assessment of the resident's reddened, scabbed, and dry skin on his left lower extremity. The concern was brought to the attention of the Director of Nursing, on 01/10/12 during the daily exit conference, conducted at 3:30 P.M. On 01/11/12 at 9:30 A.M., the Director of Nursing indicated an order was received for Vitamin E lotion for the resident's bilateral lower extremities and an assessment of the resident's leg was done. However, the assessment completed in the skilled nursing notes and provided, dated 01/09/12 at 2:00 P.M., which indicated the Vitamin E lotion not ordered until 01/10/12, was applied, indicated the following assessment "Left ankle oa (open area) continues. Wound bed has yellow slogh (sic) t/o (through out) with pink areas. Serous drainage noted to area.			

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	no odor. Surrounding skin dark pink/purple going up shin. No change from admission coloring to area.....dry/flaky skin continues bilateral lower extremities....." The redness was not measured, well documented, and the scabbed and superficially open areas on the left skin were not assessed and/or documented. On 01/13/12 at 11:50 A.M., the resident's left ankle and foot were again observed; however, the pressure ulcer dressing was not removed. There was a streak shaped area of reddened skin, approximately 1 1/2 inches wide going from the resident's outer left ankle, above the ankle bone around to the left skin area. The left shin area was noted to be reddened and had 4 scabbed areas. The largest scab, an oblong, nickel sized scab was partially removed with bloody open tissue exposed. LPN #10 indicated she was not aware of the area and she was going to get "an order" for treatment of the open skin. A tennis ball sized area of reddened skin was also noted on the resident's left inner ankle. The skin surrounding all of the reddened areas was noted to be less dry than when observed on 01/10/12. 3.1-37(a)			

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F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interview, the facility failed to initiate treatment for a pressure ulcer for 1 resident (C) of 5 residents reviewed for pressure ulcers in a sample of 24. Findings include: Resident C's clinical record was reviewed on 1/9/12 at 2:15 P.M. The record indicated the resident was admitted to the facility on 12/30/11. The nursing admission assessment dated 12/30/11 at 6:45 P.M. indicated the resident had a stage 2 pressure ulcer to their buttock measuring 1.0 centimeters (cm) x 1.0 cm. Review of the resident's initial nurse's notes dated 12/30/11 at 6:45 P.M. indicated the physician was notified of the new admission and orders received. Review of the resident's physician's orders upon admission on 12/30/11, did not indicate a treatment for a pressure ulcer to	F0314	1. Resident #C no longer resides in the facility. 2. All residents with skin conditions have been reviewed to ensure MD orders for treatment has been initiated. 3. Licensed staff have been in serviced regarding obtaining treatment orders upon admission for residents with impaired skin integrity. UM/designee will monitor compliance through admission audit for completeness. 4. Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter. AddendumThe facility will utilize the medical record audit tool 5 x per week to ensure treatments are initiated timely.	02/12/2012

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	the resident's buttock. Review of the physician progress note of 1/2/12 did not indicate the resident had a pressure ulcer. Review of the physician's orders dated 1/4/12, indicated a treatment of Xeroform gauze and dry dressing was to start to a pressure ulcer to the resident's right buttock daily. An interview with the Director of Nursing (DON) on 1/9/12 at 3:10 P.M. indicated the nurse who admitted the resident on 12/30/11 and noted the pressure ulcer failed to notify the physician and obtain treatment for the pressure ulcer. During an observation of the pressure ulcer to resident C on 1/11/12 at 2:55 P.M., the wound was on the right inner buttock and was approximately 1.0 cm x 0.2 cm and had a depth of 0.1 cm. The wound was pink, with no drainage. This Federal citation relates to Complaint IN00101871. 3.1-40(a)(2)			

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F0315 SS=E	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review, and interviews, the facility failed to ensure the bladder incontinence was thoroughly assessed and appropriate toileting and incontinence care was given, for 4 of 10 residents reviewed for incontinence in a sample of 24. (Resident #62, D, E, and 150) In addition, the facility failed to assess symptoms of a urinary tract infection for 1 of 6 residents reviewed for infections in a sample of 24. (Resident #E) Findings include: 1. The closed clinical record, reviewed on 01/13/12 at 10:00 A.M., for Resident #150, indicated she was admitted to the facility on 10/23/11 with diagnoses including, but not limited to, recent fracture of the pelvis, intractable pain issues, and dementia. A "Bowel and Bladder Assessment and Management" form, completed on	F0315	1. Resident #62, D, E bowel and bladder assessments have been reviewed and an appropriate toileting plan implemented. Resident #150 was discharged home prior to survey. Resident #E completed antibiotic therapy with no adverse reactions. 2. The facility reviewed residents with incontinence to ensure thorough assessments were completed and appropriate toileting plans were implemented. 3. Licensed staff were in serviced on documenting signs and symptoms of UTI. MDS staff was in serviced to complete through assessments for residents with incontinence and implementing	02/12/2012

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	10/23/11, the resident's admission date, indicated the resident was incontinent of both her bowels and bladder but the incontinence occurred less than 7 times. The resident's "score" indicated she was a candidate for a possible re-training or individualized training program. There was no further bowel and bladder assessment located. The initial MDS (Minimum Data Set) assessment for Resident #150, completed on 10/29/11, indicated the resident was frequently incontinent of her bowels and bladder and required extensive staff assistance for toileting needs. The CAA (Care Area Assessment) for the incontinence section of the 10/29/11 MDS assessment indicated the resident was going to be on a "Scheduled toileting" program. There was no further documentation of specific toileting patterns or other information utilized to assess the resident's bladder incontinence. Interview with the MDS coordinator, LPN #4, on 01/13/12 at 11:00 A.M., indicated they utilized the computerized toileting and/or incontinence tracking documentation; however, the documentation only documented the resident's continence or incontinence when the nursing assistants toileted and/or changed the resident due to		appropriate toileting plans. UM/designee will monitor compliance for changes in condition through medical record audit 5 x weekly. DON/designee will monitor compliance with bladder assessments by auditing 5 care plans weekly. 1.Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter.	

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	incontinence. There was no frequent patterning tracking and documentation noted for Resident #150 and in some cases there were 12 hour gaps between the incontinence documentation during the MDS assessment time frames. Review of the health care plans for Resident #150, initiated on admission, and current through the resident's discharge from the facility on 12/02/11, indicated there was no plan regarding toileting and/or incontinence needs. Interview with the MDS coordinator, LPN #4, on 01/13/12 at 11:00 A.M., confirmed there was no further assessment of the resident's incontinence, other than the one completed the day of the resident's admission, and there were no care plans initiated which addressed specific toileting needs or bladder incontinence needs. 2. During the initial tour of the facility, conducted on 01/09/12 between 11:10 A.M. - 11:35 A.M., LPN #6 indicated Resident #62 was alert and oriented, required extensive staff assistance for activities of daily living, was receiving Hospice services, but was doing so well he might be taken off of Hospice services, and was checked for incontinence and changed as needed.			

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The clinical record for Resident #62 was reviewed on 01/12/12 at 9:50 A.M. The resident had been admitted to the facility on 08/01/11, had been sent to the hospital in October 2011 for acute care needs and returned to the facility on 10/14/11.

The initial MDS assessment, completed on 08/08/11, indicated the resident was occasionally incontinent of his bladder and was continent of his bowels. However, the 10/21/11 MDS assessment, completed due to a significant change, indicated the resident had declined in transferring needs, eating ability, and was now frequently incontinent of his bowels and bladder.

Review of a bowel and bladder assessment and management form, completed for Resident #62, indicated on 08/01/11 the resident was assessed to be continent of his bowel and bladder. On 08/11/11 the resident was assessed to have exhibited less than 7 incontinent episodes of urine, was mentally aware of his toileting needs always, and required mobility assistance from one side. The "score" at the bottom of the form indicated the resident was "Continent; no further intervention required." However, the 10/14/11 assessment indicated the resident was documented as incontinent

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	of both his bowel and bladder more than 7 times but at least 1 episode continent. The resident's "score" indicated he was a possible candidate for re-training or Individualized Training. The assessment form indicated the resident had mild cognitive impairment and was usually aware of his toileting needs and required complete mobility assistance. Interview with LPN #4, the MDS coordinator, on 01/12/12 at 3:00 P.M. indicated she utilized the computerized toileting records, interviews with the resident and/or staff to determine toileting schedules and needs. There was no specific toileting patterning documentation completed for Resident #62 upon his return from the acute care center after his decline in bowel and bladder incontinence was noted. LPN #4 indicated the resident was on Hospice services and was just being checked for incontinence and changed. It was unclear why the resident was assessed on 10/14/11 as frequently incontinent of his bowels and bladder when he was only being offered incontinence management and changed after he was incontinent. On 01/12/12 at 8:37 A.M., Resident #62 was observed being transferred by CNA #8 from his Broda chair into bed. The resident indicated he did not feel good			

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	and felt like he was going to vomit. The resident then did proceed to vomit. The resident was not noted to be confused, could partially assist the nursing assistant with standing and pivoting needs, expressed correctly the need to vomit, but was not offered toileting services or a urinal. CNA #8 indicated Resident #62 was not toileted. Interview with LPN #4, the MDS coordinator on 01/13/12 at 11:00 A.M., indicated she felt the check and change care plan was appropriate when the resident returned from the acute care facility on 10/14/11. She indicated she had spoken with Resident #62 and staff, and they were now going to be offering the resident the urinal and bedpan. She indicated the resident had understood and stated he was willing to cooperate in the process. 3. Resident #E's record was reviewed 1-10-2012 at 11:30 a.m. Resident #E's diagnoses included, but were not limited to, depression, diabetes, and dementia. A physician's order dated 1-4-2012, indicated to obtain a urine sample for analysis. A physician's order dated 1-7-2012, indicated to give Macrobid (an antibiotic) 100 mg twice daily for urinary tract			

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	infection. A change of condition form dated 1-4-2012, indicated Resident #E had foul smelling urine, complained of abdominal pain and had mental status changes. The nurse's notes dated 1-4-2012 indicated the physician had been notified, but did not indicate urinary status. There was no further mention of urinary status, urine odor, abdominal pain or mental status until 1-7-2012 when the order for the antibiotic was received and noted. In an interview on 1-12-2012 at 2:00 p.m., the Director of Nursing indicated the urinary status should have been assessed daily. A current policy dated 2006, and titled Bowel/Bladder policy, provided by the Director of Nursing on 12-12-2012 at 2:45 p.m., indicated assessments for urinary events should be completed daily. 4. Resident #D's record was reviewed 1-11-12 at 1:00 p.m. Resident #D's diagnoses included, but were not limited to, heart failure, diabetes, and kidney disease. Resident #D was admitted form the hospital with a Foley catheter.			

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A physician's order dated 12-27-2011, indicated to remove Resident#D's Foley catheter.

Nurse's notes dated 12-28-2011 at 4:30 a.m., indicated Resident #D's Foley catheter had been removed.

A review of Resident #D's Bowel and Bladder assessment form dated 12-23-2011, indicated Resident #D had a Foley catheter. There was no update after the 12-23-2011 assessment.

A review of bladder tracking and 3 day voiding pattern indicated documentation regarding voiding from the "vocollect" system was tracked on 12-28-11 at 11:27 a.m., continent of urine; 12-28-11 at 2:00 p.m., continent of urine; 12-28-11 at 10:41 p.m., continent of urine; 12-29-11 at 8:44 a.m., incontinent of urine; 12-29-11 at 2:48 p.m., incontinent of urine; 12-29-11 at 11:00 p.m., incontinent of urine; 12-30-11 at 9:40 a.m., incontinent of urine; 12-30-11 at 5:24 p.m., incontinent of urine; and 12-30-11 at 10:54 p.m., incontinent of urine. There was no further documentation to indicate a pattern in voiding. The collected information was between 5 and 10 hours apart no information was available regarding Resident #D's usual pattern

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	during these gaps in voiding pattern documentation. In an interview 1-12-12 at 8:50 a.m., the Director of Nursing indicated the team reviews the vocollect system and decides what program is the best. The MDS coordinator then interviews staff and alert and oriented residents to decide what the voiding pattern is and how to best toilet the resident. In an interview on 1-12-12 at 9:30 a.m., the MDS coordinator indicated the vocollect system could not be programmed to prompt the CNAs to check on resident voiding every hour or every two hours in order to complete a true voiding pattern. A current policy dated 2006 titled Bowel/ Bladder policy indicated under bladder management retraining program the purpose of the program is to enable the resident to control urination without a catheter if possible. Under procedure, the policy indicated the toileting schedule developed should be as close to the resident's customary routine as possible. 3.1-41(a)(2)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to have adequate indication to increase a psychoactive medication for 1 of 4 residents reviewed with psychotropic medication (Resident #79). The facility further failed to monitor for side effects of a psychoactive medication for 1 of 4 residents reviewed with psychoactive medication in a sample of 24 (Resident #106). Findings include: 1. Resident #79's record was reviewed 1-12-12 at 11:45 a.m. Resident #79's	F0329	1. A depression screen has been completed for resident #79. Resident #106 has been monitored for side effects with no issues identified. 2. The facility will review residents on psychotropic medication to ensure appropriate indications for use and side effects are being monitored. 3. Licensed staff and SS will be in serviced regarding appropriate indications for psychotropic use and	02/12/2012

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	diagnoses included, but were not limited to, diabetes, depression, and stroke. A physician's order dated 9-6-11 indicated Wellbutrin (an antidepressant medication) had been ordered to be give 75 milligrams at bedtime. A subsequent physician's order dated 12-25-2011 indicated to increase the Wellbutrin to 150 milligrams every day at bedtime. A review of physician's progress note dated 12-20-2011 indicated Resident #79 had a diagnosis of depression and to continue current medications. There was no discussion of depressive features increasing or of any reason to increase the antidepressant medication. A Social Services note dated 12-30-12 indicated Resident #79's Wellbutrin had been increased due to nursing reports of episodes of crying. Review of nurse's notes for the time period of 11-1-11 to 12-25-11 did not indicate Resident #79 had any episodes of crying, withdrawal or sad facial expression. Review of Mood tracking for the time period of 12-1-2011 to 1-12012 did not		documentation of side effects. SS/designee will monitor compliance 2x weekly. 1.Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter.	

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	include any indicators of depression. In an interview on 1-12-12-2011 at 1:45 p.m. the Social Services Director indicated she had not completed a geriatric depression scale prior to the increase in the antidepressant. She further indicated there was no further documentation to support the increase in the antidepressant. 2. Resident #106's record was reviewed 1-9-2012 at 11:59 a.m. Resident #106's diagnoses included, but were not limited to, dementia, depression, and high blood pressure. On 1-9-2012 at 11:45 a.m. Resident #106 was observed sitting in her wheelchair, leaning over, sleeping. Resident #106 was awakened to eat several times, but went back to sleep until a CNA came over and finished feeding her with running conversation to keep her awake enough to eat. On 1-9-2012 at 2:05 p.m. Resident #106 was observed in her room sleeping. In an interview on 1-9-2012 at 2:20 p.m. LPN #3 indicated Resident #106 was always sleeping these days. On 1-10-2012 at 8:30 a.m., Resident #106			

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	was observed up in her wheelchair in the lounge area head bent to chest sleeping. On 1-10-2012 at 9:00 a.m. Resident #106 was observed in the dining area during an activity with her head on her chest sleeping. A current physician's order dated 1-12, indicated to give Lexapro (an antidepressant) 20 milligrams daily. A review of side effect tracking dated 11-1-2011 through 12-31-2011 did not indicate any tracking of side effects related to Lexapro use. In an interview on 1-10-2012 at 9:02 a.m., the unit manager indicated side effects should have been tracked. In an interview on 1-12-2012 at 10:00 a.m., the Administrator indicated there was no specific policy for monitoring psychoactive medication side effects, but it was understood the side effects should have been monitored. 3.1-48(a)(3) 3.1-48(a)(4)			

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F0332 SS=D	The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate of greater than 5%, for 3 of 20 residents observed during medication pass. During two separate medication passes, 3 medications of 46 opportunities observed were not dispensed as ordered by the physician for the 3 residents, #80, 73 and 69, resulting in a medication error rate of 6.5%. Findings include: 1. During observation of the first medication pass on 1/10/12, Resident #80 received Novolog R (a fast acting insulin) 6 units, given subcutaneously at 11:15 A.M. for coverage after a blood sugar glucose check of 210. Resident #80 was served food for lunch at 11:46 A.M., 41 minutes after receiving her Novolog R insulin. Review of the facility policy for Insulin Aspart, Novolog, provided by the Director of Nursing (DON) on 1/12/12 at 3:30 P.M., indicated Novolog R should be administered "immediately before a meal (i.e., meal starts within 5-10 minutes after injection)."	F0332	1. Residents #69 and 70 orders have been clarified and have not experienced any ill effects noted Resident # 80 has been assessed with no ill effects noted. 2. Residents with orders for Novolog R have the potential to be effected. 3. Licensed staff will be in serviced on administering medications as ordered by the MD, transcribing medications correctly, and administering insulin in the appropriate timeframe. UM/designee will monitor compliance through admission audit 5x weekly. SDC/designee will monitor compliance through random medication pass observation 3x weekly. 1.Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter.	02/12/2012

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	An interview with the DON on 1/12/12 at 3:30 P.M., indicated Novolog R should have been given right before the meal. 2. During observation of the second medication pass on 1/11/12 at 4:00 P.M., Resident #73 received Mucinex 600 milligrams (mg). The medication card indicated the Mucinex 600 mg was to be given three times daily. The dose administered at 4:00 P.M. was the second of three doses scheduled to be given on 01/11/12. On 1/13/12 at 11:15 A.M., review of Resident #73's physician's orders indicated when the resident was discharged from an acute care facility on 12/16/11, Mucinex 600 mg was to be given twice daily, at 8 A.M. and 5 P.M. Review of the resident's physician's orders dated 12/16/11, indicated Mucinex 600 mg was to be given three times daily, at 8 A.M., 4 P.M., and 8 P.M. An interview with the DON on 1/13/12 at 11:45 A.M., indicated the resident should have been getting Mucinex 600 mg twice daily, not three times daily. 3. During observation of the second medication pass on 1/11/12 at 4:10 P.M., Resident #69 did not receive Mucinex ER			

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	600 mg which was on the Medication Administration Record (MAR). Review of the resident's most recent physician's orders dated 12/31/11, indicated Mucinex ER 600 mg was to be given twice daily. The order was originally given on 10/9/11. Review of the resident's MARs from 10/9/11 through 1/11/12, indicated the medication had not been given at all. The MAR for Mucinex indicated the family had not brought in the medication. An interview with the DON on 1/13/12 at 11:45 A.M. indicated there was no physician's order to hold the medication and the Mucinex should have been given as ordered. 3.1-25(b)(9) 3.1-48(c)(1)			

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F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on observation, interview and record review, the facility failed to prevent a significant medication error for one resident (#80) of 20 residents observed receiving medications. Findings include: During observation of the first medication pass on 1/10/12, Resident #80 received Novolog R (a fast acting insulin) 6 units, given subcutaneously at 11:15 A.M. for coverage after a blood sugar glucose check of 210. Resident #80 was served food for lunch at 11:46 A.M., 41 minutes after receiving her Novolog R insulin. Review of the facility policy for Insulin Aspart, Novolog, provided by the Director of Nursing (DON) on 1/12/12 at 3:30 P.M., indicated Novolog R should be administered "immediately before a meal (i.e., meal starts within 5-10 minutes after injection)." An interview with the DON on 1/12/12 at 3:30 P.M., indicated Novolog R should have been given right before the meal. 3.1-25(b)(9) 3.1-48(c)(2)	F0333	1. Resident #80 has been assessed with no ill effects noted. 2. Residents with orders for Novolog R have the potential to be effected. 3. Licensed staff have been in serviced on administering insulin in the appropriate timeframe. SDC/designee will monitor compliance through random medication pass observations 3x weekly. 1.Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter.	02/12/2012

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F0364 SS=E	Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.			
	Based on interviews, the facility failed to consistently serve food at appropriate temperatures to ensure palatability for nine of ten residents in a group meeting (Residents N, O, P, Q, R, S, T, U, and W) and four of five residents interviewed individually (X, Y, Z, and A). Findings include: On 1/10/12 at 10:00 A.M. a meeting was conducted with ten alert and oriented residents. Nine of ten residents (Residents N, O, P, Q, R, S, T, U, and W) indicated the temperature of hot food was not always appropriate, not hot enough. During an individual interview with resident #X on 1/13/12 at 11:00 A.M. it was indicated the food was not always hot when she ate in her bedroom. During an individual interview with resident #Y on 1/12/12 at 1:25 P.M., it was indicated the food was often not hot enough. During an individual interview with resident #Z on 1/12/12 at 2:15 P.M., it was indicated the food that should have	F0364	1. Test trays used during survey were found to be in compliance for temperatures 2. Resident council met after the survey in January. Old business was reviewed including food temperatures and the residents stated notable improvement with no current concern. 3. Nursing and dietary staff was in serviced concerning passing trays timely to ensure proper food temperatures. The Dietary manager/designee will monitor 5 instances weekly of food temperatures to ensure compliance. 4. Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter	02/12/2012

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	been hot was sometimes cold. During an individual interview with resident #A on 1/10/12 at 11:30 A.M., it was indicated the food was mostly served cold. 3.1-21(a)(2)			

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F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	Based on observation, interview and record review, the facility failed to date and dispose of food items in unit refrigerators on 3 of 4 units and the refrigerator in the activity room. This had the potential to affect 107 of 134 residents residing in the facility. The facility further failed to maintain clean refrigerators on 2 of 4 units and the activity room. This had the potential to affect 81 of 134 residents residing in the facility. Findings include: 1. During environmental rounds on 1-11-12 at 8:43 a.m., the refrigerator in the West unit pantry was observed to have a 1.5 quart bottle of orange liquid approximately 3/4 full. There was no date on the bottle of liquid to indicate when it had been opened. Additionally, an opened squeeze container of yellow pureed food was observed to have no open date visible on the container. On 1-11-2012 at 9:17 a.m. during the environmental tour, the refrigerator in the Rehab therapy room was observed to contain a 1/4 full bottle Greek salad	F0371	1. Identified refrigerators were cleaned and any expired food was thrown away 2. All remaining activity refrigerators and unit refrigerators were reviewed for cleanliness and dated/expired foods. 3. Nursing, activity, and housekeeping staff will be in serviced on proper cleaning of unit and activity room refrigerators. They will also be in serviced on proper dating and removal of expired foods. The ED/designee will audit the refrigerators twice weekly for cleanliness, dating, and expired foods. 1.Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter.	02/12/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dressing dated as opened 7-9-2011, a 3/4 full bottle of Catalina salad dressing with no date to indicate when it had been opened, and a 1/4 full jar of sweet pickle relish dated as opened 10-13-2011. On 1-11-2012 at 9:57 a.m. during the environmental tour, the refrigerator in the East unit pantry was observed to have 1/2 full 1/2 gallon of white liquid labeled Vitamin D milk with a stamped manufacturer's expiration date of 1-3-2012. The container had no date to indicate when it had been opened. On 1-11-2012 at 10:25 a.m. during the environmental tour, the refrigerator in the Activity room was observed to contain in the freezer compartment, 3- 10 ounce packages of shredded cheddar cheese, 2 with a manufacturer's expiration date of 4-9-11 and an open date of 1-7-11, and the third with a manufacturer's expiration date of 9-7-11 and no open date. The freezer additionally contained oatmeal cookie dough in a zip lock bag dated 9-29-2011, and an opened box of individual quiche with a manufacturer's expiration date of 12-9-2010 and no open date indicated. the refrigerator compartment was observed to contain a bottle of lime juice without an open date and a manufacturer's expiration date of 9-12-2011, 1 1/2 sticks of butter with a			

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	manufacturer's expiration date of 6-14-2011, and 1/2 full jar of sweet pickle relish without an open date and a manufacturer's expiration date of 9-28-2011. In an interview on 1-11-2012 at 10:00 a.m. the Housekeeping supervisor indicate the staff was responsible for maintaining the unit refrigerators and that items should be dated when opened, disposed if not used within three days and disposed when manufacturer's expiration dates had been reached. In an interview on 1-13-2012 at 9:10 a.m. the Director of Nursing indicated there were 111 residents residing on the west, East and Rehab units. Of these 111, 4 were not to be given anything by mouth. In a policy titled Resident Refrigerators dated 2008 provided by the Administrator on 1-11-2012 at 3:00 p.m., indicated open foods will be dated and discarded four days after they are open. 2. During environmental rounds on 1-11-12 at 8:43 a.m., the refrigerator in the West unit pantry was observed to have yellow and brown splashes on the sides and bottom of the refrigerator. On 1-11-2012 at 9:57 a.m. during the			

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	environmental tour, the refrigerator in the East unit pantry was observed to have yellow substance in splotches along the left side of the refrigerator. On 1-11-2012 at 10:25 a.m. during the environmental tour, the refrigerator in the Activity room was observed to have brown smears over the side and inner surfaces of the freezer. The refrigerator compartment was observed to have 2 pools of an ivory colored liquid approximately the size of a grapefruit. In an interview on 1-11-2012 at 10:00 a.m. the Housekeeping supervisor indicated the staff was responsible for inspecting and maintaining the unit refrigerator cleanliness. In an interview on 1-13-2012 at 9:10 a.m. the Director of Nursing indicated there were 84 residents residing on the West and East units. Of these 84, 3 were not to be given anything by mouth. A policy titled Resident Refrigerators dated 2008 provided by the Administrator on 1-11-2012 at 3:00 p.m., indicated refrigerator cleanliness will be maintained. 3.1-21(i)(3)			

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review, the facility failed to store linens in a manner to prevent infection. This had the potential to affect 33	F0441	1. Resident #E has not experienced any ill effects. The utility brush and comb was removed from the linen cabinet. 2. The facility inspected all linen	02/12/2012

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	residents who resided on the East wing of the facility of 134 total residents. The facility further failed to maintain clean equipment during a dressing change for 1 of 4 residents reviewed with dressing changes in a sample of 24. (Resident #E) Findings include: 1. During the environmental tour on 1-11-12 at 8:40 a.m. in the East shower room, linens were noted to be stored in a cabinet. The cabinet was open and next to the linens with the handle under the clean linens was a utility brush and a comb containing black hair like substance. In an interview on 1-11-2012 at 8:45 a.m. the Maintenance Director indicated the brush was utilized to clean the shower chairs after use and should not be stored with the clean linen. In an interview on 1-12-2012 at 3:59 p.m. the Administrator indicated there was no specific policy regarding the storage of linen, but the linen should not have been stored with the cleaning brush. 2. Resident #E's record was reviewed 1-10-2012 at 11:30 a.m. Resident #E's diagnoses included but were not limited to diabetes, dementia and kidney failure.		closets for appropriate storage. 3. Nursing staff will be in serviced not to store anything with clean linens. Licensed staff will be in serviced on proper infection control procedures for dressing changes including utilizing clean utensils. DON/designee will monitor compliance with linen storage through random rounds 3x weekly. SDC/designee will monitor compliance with infection control practices during dressing changes through random observations 2x weekly. 4 Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafterAddendumIt is currently part of the infection control program to store clean linen away from soiled items such as soiled linen and cleaning equipment. The program does address the disinfection of small non-disposable equipment after use with individual residents	

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	On 1-11-2012 at 11:22 a.m. LPN # 1 was observed during a wound treatment to place scissors containing a yellow substance on the overbed table. LPN #1 proceeded to wash her hands, glove, pick up the scissors from the bedside table and without cleaning the scissors, cut the dressing to the size needed, apply the dressing and apply the dressing cover. In an interview on 1-12-2012 at 2 p.m. the Director of Nursing indicated the scissors should have been cleaned. This Federal citation relates to complaint IN00101871. 3.1-18(b)(1)			

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F0502 SS=D	The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on record review and interviews, the facility failed to ensure laboratory tests, ordered by the physician, were obtained timely for 3 of 21 residents reviewed for lab tests in a sample of 24. (Residents #67, 97, and E) Findings include: 1. The clinical record for Resident #67 was reviewed on 01/11/12 at 9:10 A.M. Resident #67 had diagnoses including, but not limited to, atrial fibrillation, coronary artery disease, diabetes, chronic obstructive pulmonary disease, anemia, and renal insufficiency. Review of the current physician's orders for resident #67 included an order for the laboratory tests, glycohemoglobin every 4 months and a chemistry 6 panel every 3 months, ordered on 02/09/11. Review of the laboratory test results section of the chart indicated since 02/09/11, the glycohemoglobin test had only been completed on 06/09/11 and the chemistry 6 panel had only been completed on 07/14/11 and on 11/23/11 when a physician had ordered a one time chemistry 6 panel due to a new medication.	F0502	1.Resident #67, 97 and E labs were obtained. 2.The facility reviewed all resident labs to ensure results were received and obtained labs where appropriate. 3.Licensed staff were in serviced regarding obtaining labs in a timely manner. UM/designee will monitor lab orders to ensure completeness monthly. 4.Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter.	02/12/2012

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	2. Resident #E's record was reviewed 1-10-2012 at 11:30 a.m. Resident #E's diagnoses included, but were not limited to, depression, diabetes, and dementia. A current physician's order dated 2-9-2011, indicated an AST/ALT was to be drawn every 6 months. A review of the laboratory results included on the chart indicated a AST/ALT dated 5-26-2011. In an interview on 1-12-2012 at 11:44 a.m., the Director of Nursing indicated there were no further results for the AST/ALT test and the lab tests should have been obtained sometime in November. 3. Resident #97's record was reviewed 1-9-2012 at 3:21 p.m. Resident #97's diagnoses included, but were not limited to, high blood pressure, delusions, and dementia. A current physician's order dated 6-15-2010, indicated a Complete Blood Count (CBC) was to be drawn every 6 months. A review of the laboratory results included on the chart indicated a CBC dated 3-31-2011.	F0502	1.Resident #67, 97 and E labs were obtained. 2.The facility reviewed all resident labs to ensure results were received and obtained labs where appropriate. 3.Licensed staff were in serviced regarding obtaining labs in a timely manner. UM/designee will monitor lab orders to ensure completeness monthly. 4.Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter.	02/12/2012

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	In an interview on 1-12-2012 at 11:44 a.m., the Director of Nursing indicated there were no further results for the CBC test and the lab tests should have been obtained sometime in September. In an interview on 1-12-2012, at 2:45 p.m., the Director of Nursing indicated there was no specific policy for obtaining labs, but labs should be obtained as ordered. 3.1-49(a)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
	Based on observation, record review, and interviews, the facility failed to ensure there was accurate timely documentation regarding a skin issue for 1 of 6 residents reviewed for pressure ulcers in a sample of 24. (Resident I) In addition, the facility failed to ensure the incontinence documentation was accurate for 1 of 24 residents reviewed for clinical records in a sample of 24. (Resident #152) Finding includes: 1. The clinical record for Resident I was reviewed on 01/10/12 at 2:30 P.M. Resident I was admitted to the facility on 12/23/11 with diagnosis including, but not limited to, fractured femur repair, diabetes, and coronary artery disease. The nursing admission assessment, completed on 12/23/11, indicated numbered skin conditions or a full body inspection were noted and circles were also drawn on the buttocks and right heel of the body	F0514	1. Resident #I skin assessment was completed including measurements and documentation. Resident #152 was discharged prior to survey. 2. All residents with skin conditions have been reviewed to ensure accurate assessment and documentation is in place. The facility has reviewed residents with incontinence to ensure documentation is accurate. 3. Licensed staff will be in serviced regarding completing skin assessment documentation and resident continence accurately. UM/designee will monitor skin assessment compliance through admission audits. MDSC/designee will	02/12/2012

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	diagram, but there was no assessment of the resident's buttocks and right heel noted in the record. On 01/03/12 there was a nursing note, not timed, which indicated there was a stage 2 pressure ulcer, measuring 11 centimeters by 15 centimeters on the resident's buttocks and a right heel deep tissue injury, purple in color, measuring less than 1 centimeter by less than 1 centimeter. A subsequent nursing note, dated 01/04/12, untimed, indicated the following clarification: "clarification with skin assessment. No stage II pressure on buttock area red but blanchable with some shearing. Right heel DTI is measured .3 cm by .3 cm...." Interview with the Director of Nursing, on 01/09/12 at 3:00 P.M. indicated an internal audit in response to a complaint survey completed in December 2011 resulted in the identification of the missing documentation. The admitting nurse was re-educated and instructed to document an assessment; however, her assessment was then deemed inaccurate. There was no documentation by any other nurse from 12/23/11 - 01/04/12 of the resident's buttock and right heel areas. Observation of the resident's buttocks and right heel, conducted on 01/12/12 at 9:30		monitor ongoing compliance of continence documentation through routine MDS assessment schedule. 1.Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter.	

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	A.M., indicated a very slightly red blanchable red area around the center of the resident's buttocks and a pin point sized light brown intact discoloration on the resident's right heel. 2. The closed clinical record for Resident #152 was reviewed on 01/12/12 at 2:30 P.M. Resident #152 was admitted to the facility on 10/26/11 with diagnoses including, but not limited to, left hip fractures, and seizures. A bowel and bladder assessment, completed on 10/26/11, indicated the resident was incontinent of her bowels but continent of her bladder. A subsequent bowel and bladder assessment, completed on 11/03/11, indicated the resident was continent of both her bowels and bladder. The initial MDS assessment, completed on 11/02/11, indicated the resident was totally continent of her bowels. However, nursing notes, from 11/02/11 - 11/15/11, indicated the resident was documented as having been incontinent of her bowels. Interview with the MDS coordinator, LPN #4, on 01/12/12 at 2:50 P.M., indicated the nursing documentation was inaccurate as the computerized documentation			

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	completed by the nursing assistants indicated the resident was almost always continent of her bowels or did not have a bowel movement on the assessment days utilized for the 11/02/11 initial MDS assessment. 3.1-50(a)(1) 3.1-50(a)(2)			